44.6.2 For purposes of this subpart, the term "propriety providers" means providers, whether sole proprietorships, partnerships or corporations organized and operated with the expectation of earning profits for the owners, as distinguished from providers organized and operated on a non-profit basis.

44.6.3 For the purpose of computing the allowable return, the provider's equity capital means:

44.6.3.1 The provider's investment in plant and property and equipment related to patient care (net of depreciation) and funds deposited by a provider who leases plant, property, or equipment related to patient care and is required by the terms of the lease to deposit such funds (net or noncurrent debt related to such investment or deposited funds) and,

44.6.3.2 Net working capital maintained for necessary and proper operation of patient care activities.

44.6.3.3 Notwithstanding anything in Subsection 44.6.3.1 and 44.6.3.2 debt representing loans from partners, stockholders, or related organizations, on which interest payments would be allowable as costs but for Subsection 44.5.4.1 is included in computing the amount of equity capital in order that the proceeds from such loans be treated as a part of the provider's equity capital. In computing the amount of equity capital upon which a return is allowable, investment in facilities is recognized on the basis of the historical cost.

44.6.4 Acquisitions. For facilities or tangible assets acquired, the excess of the purchase price paid for a facility or assets over (1) the historical cost of the tangible assets, or (2) the cost basis of the tangible asset, whichever is applicable, is not includable in the computation of equity capital. Loans made to finance such excess portion of the cost of such acquisitions are similarly not includable in the computation of equity capital.

44.6.5 Computation of return on equity capital. For purposes of computing the allowable return, the amount of equity capital is the average investment during the reporting period. Return on investment as an element of allowable costs is subject to apportionment in the same manner as other elements of allowable costs.

44.6.6 Unapproved capital expenditures. With respect to any capital expenditure, a provider's investment in plant, property and equipment related to patient care, and funds deposited by a provider which leases plant, property, or equipment related to patient care which are found to be expenditures which have not been submitted to the designated planning agency as required, or have been determined to be inconsistent with health facility

planning requirements, are not included in the provider's equity capital for computing the allowance for a reasonable return on equity capital.

44.6.7 Exclusion from Computation of Average Equity Capital. For the purpose of computing average equity capital, the following are examples of items not to be included in the computation:

44.6.7.1 Notes and loans receivable from owners or related organizations.

44.6.7.2 Goodwill.

44.6.7.3 Unpaid capital surplus.

44.6.7.4 Treasury Stock.

44.6.7.5 Unrealized capital appreciation surplus.

44.6.7.6 Cash surrender value of life insurance policies.

44.6.7.7 Prepaid premiums on life insurance policies.

44.6.7.8 Assets acquired in anticipation of expansion and not presently used in the provider's operation or in the maintenance of patient care activities during the rate period.

44.6.7.9 Inter-company accounts.

44.6.7.10 The portion of the value of any motor vehicle that is attributed to personal use.

44.6.7.11 Any other assets not directly related to or necessary for the provision of patient care to publicly-aided patients.

44.6.7.12 Funded Depreciation.

44.7 Workers' Compensation Worker's Compensation Insurance premiums paid to an admitted carrier; application fees, assessments and premiums paid to an authorized fully-funded trust; and premiums paid to an individual self-insured program approved by the State of Maine; are fixed costs. The Department will require the facility to be a prudent and cost conscious buyer of worker's compensation insurance. In those instances where the Department finds that a facility pays more than the going rate or does not try to minimize costs, in the absence of clear justification, the Department may exclude excess costs in determining allowable costs under Medicaid. Facilities will be able to obtain an

increase in their interim rates effective with the date that an increase in the worker's compensation insurance premium is effective by submitting copies of invoices and policies to the Division of Audit.

44.7.1 The costs of Loss-Prevention and Safety Services are allowable fixed costs to a maximum of $40.00 per covered employee per year. The wages and fringes paid to workers engaged in formal Modified or Light-Duty Early-Return-To-Work Programs are a fixed cost only to the extent that they cause a nursing facility to exceed its staffing pattern. Rehabilitation eligibility assessments are a fixed cost to a limit of $300.00 per indemnity claimant. (Rehabilitation services provided to eligible injured workers are to be paid for by their employers insurer.)

45 ESTABLISHMENT OF INCREMENTAL PAYMENT.

The Department will allow a certified Medicare provider or a facility that has applied for Medicare certification and been surveyed and found in compliance with Medicare certification requirements to apply for an incremental payment. Facilities that meet the requirements stated above and who admit residents on or after October 1, 1992 who are classified as needing NF level 4(IV) or NF level 5(V) nursing care will receive an incremental payment.

45.1 Incremental payments for direct care nursing service costs for Level IV and Level V residents. The incremental payments for direct care nursing costs for the nursing facility shall be determined by using the following formula:

Effective on or after October 1, 1992 a facility will be paid an incremental rate for each newly admitted resident requiring level IV or level V nursing care, or an existing resident who is reclassified from Level I through III to a Level IV, or reclassified from level I-IV to a level V. The incremental rate will be based on the nursing hours per day required to care for a Level IV or a Level V resident in excess of the nursing hours per day (less D.O.N.) built into the facility's existing Medicaid rate. The increase in nursing hours is divided by the nursing hours built into the facility's existing Medicaid rate to derive the percent increase of hours per day. The percent increase in hours per day is multiplied by the current nursing cost per day to determine the incremental payment to be added to the current per diem prospective rate.

Data elements required for the computation:

a) Level 4 (IV) resident is defined as requiring 5 nursing hours per day.

b) Level 5 (V) resident is defined as requiring 6.0 nursing hours per day.

c) The current base nursing hours per day less D.O.N. hours. (Data from Schedule IX of the most recent cost report.)

d) The current base nursing cost per day excluding D.O.N. costs. (Data from Schedule IV of the most recent cost report.)

e) The current direct staff cost component for the facility. (Provided by the Division of Audit.)

f) The current routine, indirect and fixed cost components for the facility. (Provided by the Division of Audit.)

g) The current prospective rate for the facility. (Provided by the Division of Audit.)

h) Data indicating the number of level IV and V residents at the facility in the base year (fiscal year beginning in 1990).

(THE EXAMPLE BELOW REFLECTS ONLY AN ADJUSTMENT FOR RESIDENTS CLASSIFIED IN NEED OF LEVEL IV SERVICES.)
Example:
Assumptions:

Current rebased prospective rate for this facility includes 3.0 nursing hour per day and $35 nursing cost per day. The current direct staff cost component for this facility is $65 $50, the indirect cost component for this facility is $5, the routine cost component is $10 and the fixed cost is $15 per day. This results in the current prospective rate for this facility equaling $80 per day.

Computation:

5.0 hours - 3.0 hours = 2.0 change - 3.0 hours = 66% increase/day * $35 = $23.10 + $80 existing rate = $103.10 Level IV rate.

45.2 The incremental payment will not be included in the calculation of the year end cost settlement for any facility. Nursing costs to be included as allowable costs will be limited to the current year's actual nursing cost per hour multiplied by the average nursing hours per day for the current year, (not to exceed the approved staffing pattern for the

facility) multiplied by the total patient days for the current year.

45.3 Existing Medicare Certified Facilities. The incremental payment rate will be effective the first day of admission or patient reclassification following the submission of the completed and adequate information as required in Principle 45.1.

45.4 Facilities applying for Medicare Certification. At the time the facility's application for Medicare certification is made to the Division of Licensure and Certification, the information required in Principle 45.1 should be on record or submitted to the Division of Audit. If the information is complete, the incremental payment rate will be effective the first day of admission in which the facility has been found in compliance with Medicare certification requirements.

50 PUBLIC HEARING

e State of Maine will provide for public hearings as necessary in our ıte Plan, according to State procedures.

60 WAIVER

The failure of the Department to insist, in any one or more instances, upon the performance of any of the terms or conditions of these Principles, or to exercise any right under these principles, or to disapprove of any practice, accounting procedure, or item of account in any audit, shall not be construed as a waiver of future performance of the right. The obligation of the Provider with respect to future performance shall continue, and the Department shall not be stopped from requiring such future performance.

70 SPECIAL SERVICE ALLOWANCE

70.1 Principle. A special ancillary service is to be distinguished from a service generally provided in the nursing facility .

70.1.1 A special ancillary service is that of an individual nature required in the case of a specific patient. This type of service is limited to professional services such as physical therapy, occupational therapy, and speech and hearing services. Special services of this nature must be billed monthly to the Department as separate items required for the case of individual recipients.

71 OMNIBUS RECONCILIATION ACT OF 1987 (OBRA 87) OBRA 1987 has eliminated the distinction between ICFs and SNFs and the method of payment by such classifications. The statue provides for only one type of nursing facility. All nursing homes are now classified as a "nursing facility" with a single payment methodology.

72 Establishment of Prospective Per Diem Rate

80.1 Principle. For the payment periods beginning on October 1, 1992, the Department will establish an prospective per diem rate to be paid to each facility until the end of its fiscal year. Each nursing facility's allowable base year costs (fiscal year beginning in 1990) as determined from the audited cost report (as filed cost report if an audit is incomplete) will be trended forward to a common fiscal year ending September 31, 1992. The base year costs will be trended forward using the inflationary factors from the table "HCFA Nursing Home Without Capital Market Basket" from the publication Health Care Costs published by DRI/McGraw - Hill as described in Section 91. Inflation factor data for salaries will be acquired from the Maine Health Care Facility Economic Trend Factor. The inflation factors will be based on the most recent DRI publications available at the times the rates are determined. The base year cost data, trended forward to September 31, 1992 will be used to compute the median costs, upper limits and incentive payments that will be the basis for computing each facility's rate. The nursing facilitys' base year rate will be inflated to the end of the nursing facilities current fiscal year. The prospective rate shall consist of four components: the direct patient care cost component as defined in Section 41 the indirect patient care cost component as defined in Section 42, the routine cost component as defined in Section 43, and the fixed cost component as defined in Section 44.

80.2 FIXED COST COMPONENT

The fixed cost component shall be determined based on the actual allowable costs as identified in Section 44 incurred by the facility in the base year.

80.3 DIRECT PATIENT CARE COST COMPONENT

The direct cost component as defined in Section 41, shall be determined by adjusting the allowable necessary and reasonable direct patient care costs (subject to the lower of approved or actual staffing limitations cited in Section 41 and section 100.1) from the base year by the inflationary factor defined in Section 91 .

80.3.1 Direct Patient Care Cost Savings. Managers of facilities who operate in an efficient and economical manner and thereby limit their direct patient care costs during their fiscal year to less than the amounts paid through the direct patient care cost component of the final prospective rate will share with the Department in the resulting savings.

For fiscal years beginning on or after October 1, 1992 direct patient care cost savings will result in the facility retaining no more than 25% of this savings subject to the following limitations:

1) Savings recognized in this cost component must be used to increase the owners equity in the nursing facility or in the instance of non-profit ownership to increase the investment in property or equipment of the nursing facility used for patient services.

Facilities which incur direct patient care costs during their fiscal year in excess of the direct patient care cost component of the prospective rate will receive no more than the amount allowed by the prospective rate unless approved by the Division of Licensing and Certification in the Department of Human Services.

For nursing facilities that have been approved for additional direct care staff since the facilities fiscal year which began in 1990, the additional approved direct patient care staffing will be added to the interim direct patient care component as a supplemental allowance. The supplemental allowance will be added to the direct patient care component after the first audit has been conducted, if it is determined that these hours have been used for one full operating year. Hours and costs associated with the supplemental allowance will be excluded from the caluculation of cost savings.

80.4 INDIRECT PATIENT CARE COST COMPONENT

Indirect Care Patient Care Cost component base year rates shall be computed as follows:

80.4.1 Using each facility's Base Year cost report, the provider's Base Year total allowable Indirect Patient Care costs shall be determined in accordance with Section 42.

80.4.2 The Base Year per diem allowable Indirect Patient Care costs for each facility shall be calculated by dividing the Base Year total allowable Indirect Patient care costs by the total Base Year resident days.

80.4.3 The Bureau of Medical Services will array all nursing facility's Base Year per diem allowable Indirect Patient Care costs adjusted to a common fiscal year by the appropriate inflationary factor, from low to high and identify the median.

80.4.4 The per diem limit shall be the median plus 15 percent.

80.4.5 Each facility's Base Year Indirect Patient Care cost per diem rate shall be the lesser of the limit set in subsection 80.44 or the facility's Base Year per diem allowable Indirect Patient Care costs.

80.5 ROUTINE CARE COST COMPONENT

Routine Care Cost component base year rates shall be computed as follows:

80.5.1 Using each facility's Base Year cost report, the provider's Base Year total allowable Routine Care costs shall be determined in accordance with Section 42.

80.5.2 The Base Year per diem allowable Routine Care costs for each facility shall be calculated by dividing the Base Year total allowable Routine care costs by the total Base Year resident days.

80.5.3 The Bureau of Medical Services will array all nursing facility's Base Year per diem allowable Routine costs adjusted to a common fiscal year by the appropriate inflationary factor, from low to high and identify the median.

80.5.4 The per diem limit shall be the median plus 10 percent.

80.5.5 Each facility's Base Year Routine Care cost per diem rate shall be the lesser of the limit set in Subsection 80.54 or the facility's Base Year per diem allowable Routine Care costs.

80.6 RATES FOR FACILITIES RECENTLY SOLD OR NEW FACILITIES

For a facility sold after December 31, 1990, the direct, indirect and routine variable rate shall be determined from the base year costs of the seller.

For new facilities entering the Medicaid Program, the indirect and routine component costs determined as equal to the statewide average for existing nursing facilities will be the basis for establishing the facility's rate through the certificate of need review. Fixed and direct patient care cost components recognized by the Medicaid program for a new facility will be determined through the current established Certiticate of Need review process. Costs determined throught the certificate of need review process must be approved by the Bureau of Medical Services for new facilities and facilities involved in change of ownership.

The Department will rely on the analysis of the Certificate of Need for nursing facilities operating under a current Certificate of Need to determine the base year level of reimbursment.

81 Interim and Subsequent Interim Rates

81.1 Interim Rate. Fifteen days prior to the beginning of the facility's fiscal year, an interim rate will be established by using the fixed cost component of the base year fiscal year and adding to it the direct, indirect and routine cost components of the base year rate inflated by the inflationary factor as defined in Section 91.

81.2 For a facility sold after December 31, 1990, the direct, indirect and routine cost components rate will be determined from the base year of the seller. In those instances in which the new owner(s) can demonstrate that the direct, indirect and routine cost component rate of the seller is inadequate and unreasonable to meet the costs which must be incurred by an efficient and economically operated facility in order to provide care and services in conformity with applicable State and Federal regulations, the Department will negotiate a new direct, indirect and routine cost component rate for the facility.

81.3 Subsequent Interim Rate. For subsequent years, the direct, indirect and routine cost components rate shall be determined from the base years reasonable and necessary direct, indirect, and routine rates and adjusting those rates by the Maine Health Care Facility Economic Trend Factor as defined in Section 91.

The Department will assign an interim prospective rate at least fifteen (15) days prior to the commencement of a facility's fiscal year using the most recent inflationary factor available to the Department.

Upon the completion of a final audit of a facility's cost report, the Department will assign the facility a final prospective rate.

81.4 Establishment of the Direct, Indirect and Routine Rate Upon Sale of a Facility. For a facility sold after December 31, 1990, the direct, indirect and routine rate will be determined from the base year of the seller. In those instances in which the new owner(s) can demonstrate that the direct, indirect and routine rate of the seller is inadequate and unreasonable to meet the costs which must be incurred by an efficient and economically operated facility in order to provide care and services in conformity with applicable State and Federal regulations, the Department may negotiate a new direct, indirect and routine rate for the facility which must be approved by the Bureau of Medical Services.